CHAPTER IV

COVERED SERVICES AND LIMITATIONS

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MEDALLION

MEDALLION is a mandatory Primary Care Case Management program that enables Medicaid recipients to select their personal Primary Care Physician (PCP), who will be responsible for providing or coordinating (or both) the services necessary to meet all of their health care needs. MEDALLION promotes the physician/patient relationship, preventive care, and patient education while reducing the inappropriate use of medical services. The PCP serves as a gatekeeper for access to most other non-emergency services that the PCP is unable to deliver through the normal practice of primary care medicine. The PCP must provide authorization for any other non-emergency, non-exempted services in order for another provider to be paid for services rendered. To provide services to a MEDALLION recipient, prior authorization (PA) from the recipient's PCP is required. Before rendering services, either direct the patient back to his/her PCP to request a referral or contact the PCP to inquire whether a referral is forthcoming. The PCP's name and telephone number are listed on the recipient's MEDALLION identification card. Refer to the MEDALLION section of this Provider Manual for further details on the program.

No PCP referral is required for the services set forth in this chapter. However, it is the responsibility of the provider of these services to coordinate service delivery and the recipient's needs with the PCP.

MEDALLION II

In areas where the Medallion II program is available, the majority of Medicaid recipients receive primary and acute care through mandatory enrollment in Managed Care Organizations (MCOs). There are at least two MCOs per area that have contracts to serve Medicaid recipients. Effective January 1, 1996, the program initially covered Medicaid populations located in Chesapeake, Hampton, Newport News, Norfolk, Portsmouth, Poquoson, and Virginia Beach. Effective November 1, 1997, Medallion II expanded to cover populations located in the counties of York, James City, Gloucester, and Isle of Wight and the cities of Williamsburg and Suffolk. Effective April 1, 1999, populations located in the Richmond metropolitan area, Eastern Shore, and Southwest Tidewater regions were covered.

The services described in this chapter are not included in the MCO contracts. The recipient may access any of the services through any Medicaid-enrolled provider. Also, the MCO may refer a recipient to any of these services. It is the responsibility of the provider of these services to coordinate service delivery and the recipient's needs with the MCO.

COVERED SERVICES AND LIMITATIONS

Introduction

The mental health services described below are covered under the Medicaid Program. Providers of services must meet the qualifications described under "Provider Participation

Requirements" in Chapter II of this manual. In addition, where applicable, criteria for licensed mental health professionals (LMHPs), qualified mental health professionals (QMHPs), paraprofessionals, and qualified substance abuse professionals must be met.

Services must be provided in conjunction with the current assessment and evaluation of the recipient's support needs and in accordance with the Individualized Service Plan (ISP) developed for that individual. A physical examination is recommended as a component of the assessment for all Community Mental Health Rehabilitative Services.

For Community Mental Health Rehabilitative Services, the Individualized Service Plan (ISP) is a comprehensive service plan, which is developed by the designated provider and addresses the total needs of the recipient in all life areas. An ISP is also developed by each service provider, which is related solely to the specific services provided to the recipient. The ISP is defined in the "Exhibits" section at the end of this chapter.

Under the Medicaid Program, mental health clinic services are also covered. The recognized providers of these services, a description of the services, billing procedures, and other items are included in the *Mental Health Clinic* Provider Manual issued by the Department of Medical Assistance Services (DMAS). The covered services described below are independent of the mental health clinic services unless specifically prohibited.

Medicaid recipients who are receiving Community Mental Health Rehabilitative Services may receive any other Medicaid-covered service for which they qualify unless specifically prohibited as described for each service.

Medicaid recipients enrolled with a contracted Medicaid MCO participating in Medallion II are eligible to receive Community Mental Health Rehabilitative Services. Close coordination with the MCO's mental health case management team is strongly encouraged to ensure that the total needs of the recipient as developed in the ISP are met.

Transportation of the recipient to medical appointments must be billed to the Medicaid transportation broker and not included as part of the service.

COMMUNITY MENTAL HEALTH SERVICES

The following mental health services are covered under the Medicaid Program. Carefully read the criteria, service definitions, and maximum service limits in the discussion of each service. Limitations are counted from date-of-service initiation. Services are delivered to specific populations based on the mental health needs of each individual.

SERVICE CRITERIA AND DEFINITIONS - EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT) FOR INDIVIDUALS UNDER THE AGE OF 21

Intensive In-Home Services for Children and Adolescents (H2012)

Service Definition

Covered services are time-limited interventions provided typically, but not solely, in the home of a child or adolescent who is: (1) at risk of being moved into an out-of-home placement or (2) being transitioned to home from an out-of-home placement due to a documented medical need of the child.

Home is defined as the family residence and includes a child living with natural parents, relatives, or a guardian, or the family residence of the child's permanent or temporary foster care or pre-adoption placement.

Eligibility Criteria

Individuals must demonstrate a clinical necessity arising from a condition due to mental, behavioral, or emotional illness that results in significant functional impairments in major life activities. Individuals must meet at least two of the following criteria on a continuing or intermittent basis:

1. Have difficulty in establishing or maintaining normal interpersonal relationships to such a degree that they are at risk of hospitalization or out-of-home placement because of conflicts with family or community; and/or

2. Exhibit such inappropriate behavior that repeated interventions by the mental health, social services, or judicial system are necessary; and/or

3. Exhibit difficulty in cognitive ability such that they are unable to recognize personal danger or recognize significantly inappropriate social behavior.

Services shall be used when out-of-home placement, due to the clinical needs of the child, is a risk and either:

1. Services that are far more intensive than outpatient clinic care are required to stabilize the child in the family situation; or

2. The child's residence, as the setting for services, is more likely to be successful than a clinic.

With respect to both 1 and 2, at least one parent or responsible adult with whom the child is living must be willing to participate in in-home services, with the goal of keeping the child with the family. Services must be directed toward the treatment of the eligible child.

Services may also be used to facilitate the transition to home from an out-of-home placement when services more intensive than outpatient clinic care are required for the transition to be successful. The child and responsible parent or guardian must be available and must agree to participate in the transition.

Required Activities

- At admission, an appropriate face-to-face assessment will be made and documented by the QMHP and approved by the LMHP within 30 days indicating that service needs can best be met through intensive in-home services.

- An ISP must be completed by the QMHP within 30 days of the initiation of services and must document the need for services. The ISP will demonstrate the need for a minimum of three hours a week of intensive in-home service. If the minimum three hours is not provided, there must be documentation of a valid reason. Intensive in-home services below the three-hour-per-week minimum may be covered when services are being tapered off prior to discharge. However, variations in the pattern of service delivery must be consistent with the frequency of services specified for the goals and objectives of the service plan. Service plans must incorporate a discharge plan, which identifies transition from intensive in-home to less intensive or non-home-based services.

- Services include: crisis treatment, individual and family counseling, communication skills counseling (to assist the child and parents in practicing appropriate problem-solving, anger management, interpersonal interaction, etc.), case management activities, coordination with other required services, and 24-hour emergency response.

- Services must be delivered primarily in the child's home with the child present. If it is determined that the content of the session is inappropriate for the child to be present, this must be documented. Documentation must reflect the necessity of providing services without the child present.

- In some circumstances, such as lack of privacy or unsafe conditions, services may be provided in the community instead of the home, if this is supported by the assessment and the ISP.

- Services must be provided by a QMHP or LMHP.

- If case management is being provided by any case management agency, the Intensive In-Home provider must notify the case management agency. Targeted Case Management, including mental health and Treatment Foster Care-Case Management, cannot be billed while the child is receiving Intensive In-Home Services.

- Because Intensive In-Home Services are an EPSDT service, a referral should be made to the child's health care provider for a well child or EPSDT screening.

Limitations

- Since case management services are an integral and inseparable part of intensive in-home services, case management services cannot be billed separately for periods of time when intensive in-home services are being reimbursed. Coordination must occur for all services that the child receives.
- Service is not appropriate for a family while the child is not living in the home or for families being kept together until an out-of-home placement for the child can be arranged.
- Staff travel time is excluded.

Service Units and Maximum Service Limitations

- The unit of service for intensive in-home service is one hour.
- There must be a minimum of three hours per week.
- A maximum of 26 weeks of intensive in-home services may be offered per year.
- Providers may request a review by DMAS for continuation of the service. The child must continue to meet medical necessity criteria.

Therapeutic Day Treatment For Children And Adolescents (H0035 Modifier HA)

Service Definition

Covered services are a combination of psychotherapeutic interventions combined with education and mental health treatment offered in programs of two or more hours per day with groups of children and adolescents.

Eligibility Criteria

Children and adolescents who have a mental, behavioral, or emotional illness that results in significant functional impairments in major life activities are eligible. This determination of significant disability should be based upon consideration of the social functioning of most children who are the same age. The disability must have become more disabling over time and must require significant intervention through services that are supportive, intensive, and offered over a protracted period of time in order to provide therapeutic intervention. Individuals must demonstrate a clinical necessity for the service arising from a condition due to mental, behavioral, or emotional illness that results in significant functional impairments in major life activities. Individuals must meet **at least two** of the following on a continuing or intermittent basis:

1. Have difficulty in establishing or maintaining normal interpersonal relationships to such a degree that they are at risk of hospitalization or out-of-home placement because of conflicts with family or community.

2. Exhibit such inappropriate behavior that repeated interventions by the mental health, social services, or judicial system are necessary.

3. Exhibit difficulty in cognitive ability such that they are unable to recognize personal danger or recognize significantly inappropriate social behavior.

In addition to meeting two of the three criteria listed above, children and adolescents must meet one of the following:

1. Require year-round treatment in order to sustain behavioral or emotional gains.

2. Behavioral and emotional problems are so severe they cannot be handled in self-contained or resource emotionally disturbed (ED) classrooms without this programming during the school day or as a supplement to the school day or school year.

3. Would otherwise be placed on homebound instruction because of severe emotional or behavioral problems, or both, that interfere with learning.

4. Have deficits in social skills, peer relations, or dealing with authority; are hyperactive; have poor impulse control; or are extremely depressed or marginally connected with reality.

5. Children in preschool enrichment and early intervention programs when the children's emotional or behavioral problems, or both, are so severe that they cannot function in these programs without additional services.

Required Activities

- There must be a face-to-face diagnostic assessment by a QMHP with review and authorization by a LMHP prior to service initiation.

- The assessment must be reviewed and updated at least annually.

- An ISP must be completed by a QMHP documenting the need for services within 30 days of service initiation.

- Evaluation, medication education and management, opportunities to learn and use daily living skills and to enhance social and interpersonal skills (e.g., problem-solving, anger management, community responsibility, increased impulse control, appropriate peer relations, etc.), and individual, group, and family counseling.

- Services must be provided in accordance with the ISP.

- At a minimum, services are provided by qualified paraprofessionals under the supervision of a QMHP. (This will include current experienced staff who do not meet the criteria.)

- Supervision is demonstrated by the QMHP by a review of progress notes, the recipient's progress towards achieving ISP goals and objectives, and recommendations for change based on the recipient's status. Supervision must occur and be documented in the clinical record monthly.

- Paraprofessionals who do not meet the experience requirement listed in Chapter II may provide services for Medicaid reimbursement if they are working directly with a qualified paraprofessional on-site and being supervised by a QMHP. Supervision must include on-site observation of services, face-to-face consultation with the paraprofessional, a review of the progress notes, the consumer's progress towards achieving ISP goals and objectives, and recommendations for change based on the recipient's status. Supervision must occur and be documented in the clinical record monthly.

- The program must operate a minimum of two hours per day and may offer flexible program hours (e.g., before school, after school, or during the summer).

- The minimum staff-to-youth ratio must ensure that adequate staff is available to meet the needs of the youth identified on the ISP.

- If case management is being provided, there must be coordination with the case management agency.

- Services must not duplicate those services provided by the school.

Service Units and Maximum Service Limitations

- One unit of service is defined as a minimum of two but less than three hours on a given day.

- Time for academic instruction when no treatment activity is going on cannot be included in the billing unit.

- A maximum of 780 units may be offered per year.

- Staff travel time is excluded.

<u>Community-Based Residential Services for Children and Adolescents under 21 (Level A)</u>

Service Definition

Community-Based Residential Services for Children and Adolescents under 21 are a combination of therapeutic services rendered in a residential setting. This residential service will provide structure for daily activities, psycho-education, therapeutic supervision, and psychiatric treatment to ensure the attainment of therapeutic mental health goals as identified in the ISP. The child/adolescent must also receive psychotherapy services in addition to the therapeutic residential services. Room and board costs are not included in the reimbursement for this service. Authorization is required for Medicaid reimbursement. Only programs/facilities with

16 or fewer beds are eligible to provide this service. This service does not include interventions and activities designed only to meet the supportive non-mental health special needs, including but not limited to personal care, habilitation, or academic educational needs of the recipient.

Eligibility Criteria

Individuals qualifying for this service must demonstrate medical necessity for the service arising from a condition due to mental, behavioral, or emotional illness, which results in significant functional impairments in major life activities in the home, school, at work, or in the community. The service must reasonably be expected to improve the child's condition or prevent regression so that the services will no longer be needed.

The individual is eligible for this service when:

A) The recipient is medically stable, but needs some intervention to comply with mental health treatment; AND

B) The recipient's needs cannot be met with a less intense service; AND

C) An assessment demonstrates at least two areas of moderate impairment. A moderate impairment is defined as a major or persistent disruption. (The state uniform assessment tool must be used by the locality for Comprehensive Services Act (CSA) children/adolescents and must be current to within 30 days of placement). For non-CSA children, an assessment must be made noting at least two moderate impairments within the past 30 days. A moderate impairment is evidenced by, but not limited to:

(1) Frequent conflict in the family setting such as credible threats of physical harm. Frequent is defined as more than expected for the child's age and developmental level.

(2) Frequent inability to accept age-appropriate direction and supervision from caretakers, family members, at school, or in the home or community.

(3) Severely limited involvement in social support, which means significant avoidance of appropriate social interaction, deterioration of existing relationships, or refusal to participate in therapeutic interventions.

(4) Impaired ability to form a trusting relationship with at least one caretaker in the home, school, or community.

(5) Limited ability to consider the effect of one's inappropriate conduct on others and interactions consistently involving conflict, which may include impulsive or abusive behaviors.

Required Activities

- Provision of individualized and intensive supervision and structure of daily living designed to minimize the occurrence of behaviors related to functional deficits;
- Ensure safety during the presentation of out-of-control behaviors;
- Focus treatment interventions on functional problems and skill acquisition to deal with them;
- Direct and active intervention in assisting individuals in the process of being involved in and maintaining involvement in naturally occurring community support systems and supporting the development of personal strengths;
- Psycho-educational programming, which is part of the residential program, must include, but is not limited to, development or maintenance of daily living skills, anger management, social skills, family living skills, communication skills, and stress management. The child must participate in seven (7) psycho-educational activities per week. The activities must be documented;
- In addition to the residential services, the child must receive, at least weekly, individual psychotherapy that is provided by a LMHP. If provided by a Medicaid-enrolled provider, the psychotherapy services may be billed separately and must be prior authorized in addition to the authorization for the residential services. (See *Psychiatric Services* Provider Manual, Chapter IV, for details on outpatient pre-authorization procedures.) If the weekly psychotherapy is missed due to illness or vacation, written justification must be in the clinical record. More than three (3) missed sessions per quarter will be considered excessive. Reasonable attempts should be made to make up missed sessions;
- The facility/group home must coordinate services with other providers; and
- The staff ratio must be at least 1 to 6 during the day and at least 1 to 10 while the children/adolescents are scheduled to be asleep.

Authorization of Services

Level A residential treatment shall be authorized by an independent team. Criteria for the independent team is as follows:

For CSA children, the Family Assessment and Planning Team's (FAPT) identification of the need for the service and the Community Policy and Management Team's (CPMT) authorization for payment will constitute authorization by an independent team. The child or adolescent's Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) provider must also identify the need for the service.

For non-CSA children, the authorizing independent team shall consist of the child or

adolescent's EPSDT provider and a LMHP not affiliated with the residential provider. If the child or adolescent is away from home, as in another level of residential treatment, and cannot access the PCP or EPSDT screener, another physician who has knowledge of the child/adolescent may substitute for the EPSDT provider.

The authorization will be in effect for six months. All criteria must continue to be met during the authorization period for billing to take place. A qualified mental health provider must re-authorize the service after six months. The authorization must also be signed by a licensed mental health provider. The licensed mental health provider for the re-authorization may be an independent practitioner or may be affiliated with the residential program. For CSA children, documentation from the CPMT that authorizes continuation of the service must be in the client's record.

Independent Team Certification

At least one member of the independent certifying team must have pediatric mental health expertise.

A. For an individual who is already a Medicaid recipient when he/she is admitted to a facility or program, certification must be made by an independent certifying team that:

   1) Includes a licensed physician who:

      (i) Has competence in diagnosis and treatment of pediatric mental illness; and
      (ii) Has knowledge of the recipient's mental health history and current situation.

   2) Signs and dates the certification. Signatures must include the physician and the team. For CSA children, the majority of the FAPT and a physician must sign and date the certification. For non-CSA children, the LMHP and a physician must sign and date the certification.

B. For a recipient who applies for Medicaid while an inpatient in the facility or program, the certification must:

   1) Be made by the team responsible for the ISP;

   2) Cover any period of time before the application for Medicaid eligibility for which claims for reimbursement by Medicaid are made; and

   3) Be signed and dated by a physician and the team.

Required Information for Authorization

Information that is required in order to obtain admission authorization for Medicaid payment must include:

1. An assessment demonstrating at least two areas of moderate impairment, as defined in the "Eligibility Criteria" section on page 8. For CSA children/adolescents, the state uniform assessment tool must be submitted. It must indicate at least two areas of moderate impairment, as defined in the "Eligibility Criteria" section. The uniform assessment tool must be completed by the locality. For non-CSA children and adolescents, an assessment must identify at least two areas of moderate impairment. The assessments must be current to within 30 days.

2. The team's authorization (CSA) or the assessment by the EPSDT provider and a LMHP (non-CSA) must include child-specific descriptions, and, for CSA children, be supported by the current Child and Adolescent Functional Assessment Scale (CAFAS). The documentation must state that:

    a. Ambulatory care resources available in the community do not meet the specific treatment needs of the child;

    b. Proper treatment of the child's psychiatric condition requires services in a community-based residential program; and

    c. The services can reasonably be expected to improve the child's condition or prevent regression so that the services will no longer be needed.

3. Additional required written documentation must include all of the following:

    a. Diagnosis, as defined in the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition (DSM-IV, effective October 1, 1996), including Axis I (Clinical Disorders), Axis II (Personality Disorders/Mental Retardation), Axis III (General Medical Conditions), Axis IV (Psychosocial and Environmental Problems), and Axis V (Global Assessment of Functioning);

    b. A description of the child's behavior during the 30 days immediately prior to admission;

    c. A description of alternative placements tried or explored and the outcomes of each placement;

    d. The child's functional level. (The CAFAS, DSM-IV diagnosis, and description of problem behaviors prior to admission may provide this information.);

    e. The level of family support available; and

    f. The initial ISP.

Continued Stay Criteria for Level A

1. For re-authorization, a current ISP and a current (within 30 days) summary of progress related to the goals and objectives on the ISP must document the need for the continuation of the service.

2. For re-authorization to occur, either the desired outcome or level of functioning has not been restored or improved, in the time frame outlined in the child's ISP or the child continues to be at risk for relapse based on history or the tenuous nature of the functional gains, and use of less intensive services will not achieve stabilization. Any one of the following must apply:

   a. The child has achieved initial ISP goals but additional goals are indicated that cannot be met at a lower level of care.

   b. The child is making satisfactory progress toward meeting goals but has not attained ISP goals, and the goals cannot be addressed at a lower level of care.

   c. The child is not making progress, and the ISP has been modified to identify more effective interventions.

   d. There are current indications that the child requires this level of treatment to maintain level of functioning as evidenced by failure to achieve goals identified for therapeutic visits or stays in a non-treatment residential setting or in a lower level of residential treatment.

Discharge Criteria

Medicaid reimbursement is not available when other less intensive services may achieve stabilization.

1. Reimbursement shall not be made for this level of care if either of the following applies:

   a. The level of functioning has improved with respect to the goals outlined in the ISP, and the child can reasonably be expected to maintain these gains at a lower level of treatment; or

   b. The child no longer benefits from service as evidenced by absence of progress toward ISP goals for a period of 60 days.

Individualized Service Plan (ISP)

Services must be provided according to an ISP. The ISP must be completed within 30 days of authorization for Medicaid reimbursement. The ISP must include:

- Diagnosis, symptoms, complaints, and complications indicating the need for admission;
- Description of the functional level of the child/adolescent;
- Treatment objectives with short- and long-term goals;
- Any orders for medications, treatments, restorative and rehabilitative services, activities, therapies, social services, diet, and special procedures recommended for the health and safety of the patient;
- Plans for continuing care, including review and modification to the ISP; and
- Plans for discharge.

The ISP must:

- Be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral, and developmental aspects of the child's situation and must reflect the need for residential psychiatric care;
- Be based on input from school, home, other healthcare providers, the child, and family (or legal guardian);
- State treatment objectives that include measurable short-term and long-term goals and objectives, with target dates for achievement;
- Prescribe an integrated program of therapies, activities, and experiences designed to meet the treatment objectives related to the diagnosis;
- Describe comprehensive discharge plans with related community services to ensure continuity of care upon discharge with the child's family, school, and community.

The ISP must be reviewed at least every 30 days. The review must include:

- The response to services provided; and
- Recommended changes in the plan as indicated by the child's overall response to the ISP interventions; and
- Determinations regarding whether the services being provided continue to be required; and

- Updates must be signed and dated by the service provider.

Therapeutic Passes

A. Therapeutic passes are permitted if the goals of the pass are part of the master treatment plan. The goals of a particular visit must be documented prior to granting the pass. When the child or adolescent returns from the pass, the response to the pass must be documented. Passes should begin with short lengths of time (e.g., 2-4 hours) and progress to a day pass. The function of the pass is to assess the recipient's ability to function outside the structured environment and to function appropriately within the family and community.

B. Overnight passes may occur only after the completion and documentation of successful day passes and as a part of the discharge plan. Outcomes of the therapeutic leave must be documented. No more than 24 days of therapeutic leave annually are allowed. Days of leave are counted from the date of admission to Medicaid covered services at the A and B levels. Overnight passes from Level C Residential Treatment Services are not included in the allowance for Levels A and B. (Please refer to the *Psychiatric Services* Provider Manual for Level C Residential Treatment.) If a child/adolescent has successfully completed day passes at a higher level of care, the child/adolescent may be granted overnight passes prior to the completion of day passes at the new program if therapeutically indicated.

Limitations

DMAS will reimburse only for services provided in facilities or programs with no more than 16 beds. The total number of beds will be determined by including all beds located within the program/facility and on any adjoining or nearby campus or site.

If a provider operates separate residences that are 16 beds or less and are in distinctly different areas of a locality (for example, greater than one mile apart), the bed count will only apply to each residence. Each residence that is 16 beds or less will be eligible for Medicaid reimbursement.

DMAS does not pay for programs/facilities that only provide independent living services.

Service Units and Maximum Service Limitations

The service is limited to one unit daily. The rate includes payment for therapeutic services rendered to the child. Room and board costs are not included.

<u>Therapeutic Behavioral Services (Level B)</u>

Service Definition

Community Based Residential Services for Children and Adolescents under 21 are a combination of therapeutic services rendered in a residential setting. This service will provide structure for daily activities, psycho-education, therapeutic supervision, and psychiatric treatment to ensure the attainment of therapeutic mental health goals as identified in the ISP.

The child/adolescent must also receive psychotherapy services in addition to the therapeutic residential services. Room and board costs are not included in the reimbursement for this service. Authorization is required for Medicaid reimbursement. Only programs/facilities with 16 or fewer beds are eligible to provide this service. This service does not include interventions and activities designed only to meet the supportive non-mental health special needs, including but not limited to personal care, habilitation, or the academic educational needs of the recipients.

Eligibility Criteria

Individuals qualifying for this service must demonstrate medical necessity for the service arising from a condition due to mental, behavioral, or emotional illness, which results in significant functional impairments in major life activities in the home, school, at work, or in the community. The service must reasonably be expected to improve the child's condition or prevent regression so that the services will no longer be needed.

The individual is eligible for this service when:

A. He/she is medically stable, but must need some intervention to comply with mental health treatment; AND

B. The individual's needs cannot be met with a less intense service; AND

C. An assessment demonstrates at least two areas of moderate impairment. A moderate impairment is defined as a major or persistent disruption. The state uniform assessment tool must be used by the locality for CSA children/adolescents and must be current to within 30 days of placement. For non-CSA children, an assessment must be made noting at least two moderate impairments within the past 30 days. A moderate impairment is evidenced by, but not limited to:

    1. Frequent conflict in the family setting; for example, credible threats of physical harm. Frequent is defined as more than expected for the child's age and developmental level.

    2. Frequent inability to accept age-appropriate direction and supervision from caretakers, family members, at school, or in the home or community.

    3. Severely limited involvement in social support; which means significant avoidance of appropriate social interaction, deterioration of existing relationships, or refusal to participate in therapeutic interventions.

    4. Impaired ability to form a trusting relationship with at least one caretaker in the home, school, or community.

    5. Limited ability to consider the effect of one's inappropriate conduct on others and/or interactions consistently involving conflict, which may include impulsive or abusive behaviors.

Required Activities

- Provision of individualized and intensive supervision and structure of daily living designed to minimize the occurrence of behaviors related to functional deficits;
- Ensure safety during the presentation of out-of-control behaviors;
- Focus treatment interventions on functional problems and skill acquisition to deal with them;
- Direct and active intervention in assisting recipients in the process of being involved in and maintaining involvement in naturally occurring community support systems and supporting the development of personal strengths;
- Psycho-educational programming, which is part of the residential program, must include, but is not limited to, development or maintenance of daily living skills, anger management, social skills, family living skills, communication skills, and stress management. The child must participate in seven (7) psycho-educational activities per week. The activities must be documented;
- The staff ratio must be at least 1 to 4 during the day and at least 1 to 8 while the children/adolescents are scheduled to be asleep;
- In addition to the residential services, the child must receive, at least weekly, individual psychotherapy that is provided by a LMHP. If provided by a Medicaid-enrolled provider, the psychotherapy services may be billed separately and must be prior authorized in addition to the authorization for the residential services. (See *Psychiatric Services* Provider Manual, Chapter IV, for details on outpatient pre-authorization procedures.) If the weekly psychotherapy is missed due to illness or vacation, written justification must be in the clinical record. More than three (3) missed sessions per quarter will be considered excessive. Reasonable attempts should be made to make up missed sessions. Individuals receiving Therapeutic Behavioral Services (Level B) must also receive group psychotherapy that is provided as part of the program. If provided by a Medicaid-enrolled LMHP, group psychotherapy may be billed separately and must be prior authorized in addition to the authorization for the residential services (See *Psychiatric Services* Provider Manual, Chapter IV, for details on outpatient pre-authorization procedures) ; and
- The facility/group home must coordinate services with other providers.

Authorization of Services

Level B residential treatment shall be authorized by an independent team. Criteria for the independent team are listed below. For CSA children, the Family Assessment and Planning Team's (FAPT) identification of the need for the service and the Community Policy and Management Team (CPMT) authorization for payment will constitute authorization by an independent team. The child or adolescent's Early, Periodic, Screening, Diagnosis, and

Treatment (EPSDT) provider must also identify the need for the service.
For non-CSA children, the authorizing independent team shall consist of the child or adolescent's EPSDT provider and a LMHP not affiliated with the residential provider. If the child or adolescent is away from home, as in another level of residential treatment, and cannot access the primary care provider or EPSDT screener, another physician who has knowledge of the child/adolescent may substitute for the EPSDT provider.

The authorization will be in effect for six months. All criteria must continue to be met during the authorization period for billing to take place. A licensed mental health provider must reauthorize the service after six months. The licensed mental health provider for the re-authorization may be an independent practitioner or may be affiliated with the residential program. For CSA children, documentation from the CPMT that authorizes continuation of the service must be in the client's record.

Independent Team Certification

At least one member of the independent certifying team must have pediatric mental health expertise.

A. For an individual who is already a Medicaid recipient when he/she is admitted to a facility or program, certification must be made by an independent team that:

   1. Includes a licensed physician who:

      i.) Has competence in diagnosis and treatment of pediatric mental illness; and

      ii.) Has knowledge of the recipient's mental health history and current situation.

   2. Signs and dates the certification. Signatures must include the physician and the team. For CSA children, the majority of the FAPT and a physician must sign and date the certification. For non-CSA children, the LMHP and a physician must sign and date the certification.

B. For a recipient who applies for Medicaid while an inpatient in the facility or program, the certification must:

   1. Be made by the team responsible for the ISP;

   2. Cover any period of time before the application for Medicaid eligibility for which claims for reimbursement by Medicaid are made; and

   3. Be signed and dated by a physician and the team.

Required Information for Authorization

Information that is required in order to obtain admission authorization for Medicaid payment must include:

1. An assessment demonstrating at least two areas of moderate impairment, as defined in the Eligibility Criteria section above. For (CSA) children/adolescents, the state uniform assessment tool must be submitted. It must indicate at least two areas of moderate impairment, as defined above. The uniform assessment tool must be completed by the locality. For non-CSA children and adolescents, an assessment must identify at least two areas of moderate impairment. All criteria must continue to be met during the authorization period for billing to take place.

2. The team's authorization (CSA) or the assessment by the EPSDT provider and a LMHP (non-CSA) must include child-specific descriptions and, for CSA children, be supported by the current CAFAS. The documentation must state that:

    a. Ambulatory care resources available in the community do not meet the specific treatment needs of the child;

    b. Proper treatment of the child's psychiatric condition requires services in a community-based residential program; and

    c. The services can reasonably be expected to improve the child's condition or prevent regression so that the services will not be needed.

3. Additional required written documentation must include all of the following:

    a. Diagnosis, as defined in the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition (DSM-IV, effective October 1, 1996), including Axis I (Clinical Disorders), Axis II (Personality Disorders/Mental Retardation), Axis III (General Medical Conditions), Axis IV (Psychosocial and Environmental Problems), and Axis V (Global Assessment of Functioning);

    b. A description of the child's behavior during the 30 days immediately prior to admission;

    c. A description of alternative placements tried or explored and the outcomes of each placement;

    d. The child's functional level and clinical stability. (The CAFAS, DSM-IV diagnosis, and description of problem behaviors prior to admission may provide this information.);

    e. The level of family support available; and

    f. The initial ISP.

Continued Stay Criteria for Level B

1. For re-authorization, a current Individual Service Plan (ISP) and a current (within 30 days) summary of progress related to the goals and objectives on the ISP must document the need for the continuation of the service.

2. For re-authorization to occur, either the desired outcome or level of functioning has not been restored or improved in the time frame outlined in the child's ISP, or the child continues to be at risk for relapse based on history or the tenuous nature of the functional gains and use of less intensive services will not achieve stabilization. Any one of the following must apply:

    a. The child has achieved initial ISP goals but additional goals are indicated that cannot be met at a lower level of care.

    b. The child is making satisfactory progress toward meeting goals but has not attained ISP goals, and the goals cannot be addressed at a lower level of care.

    c. The child is not making progress, and the ISP has been modified to identify more effective interventions.

    d. There are current indications that the child requires this level of treatment to maintain level of functioning as evidenced by failure to achieve goals identified for therapeutic visits or stays in a non-treatment residential setting or in a lower level of residential treatment.

Discharge Criteria

Medicaid reimbursement is not available when other less intensive services may achieve stabilization.

1. Reimbursement shall not be made for this level of care if either of the following applies:

    a. The level of functioning has improved with respect to the goals outlined in the ISP, and the child can reasonably be expected to maintain these gains at a lower level of treatment; or

    b. The child no longer benefits from service as evidenced by absence of progress toward service plan goals for a period of 60 days.

Individualized Service Plan (ISP)

Services must be provided according to an ISP. The ISP must be completed within 30 days of authorization for Medicaid reimbursement. The ISP must include:

- Diagnosis, symptoms, complaints, and complications indicating the need for admission;
- Description of the functional level of the child/adolescent;
- Treatment objectives with short- and long-term goals;
- Any orders for medications, treatments, restorative and rehabilitative services, activities, therapies, social services, diet, and special procedures recommended for the health and safety of the patient;
- Plans for continuing care, including review and modification to the ISP; and
- Plans for discharge.

The ISP must:

- Be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral, and developmental aspects of the child's situation and must reflect the need for residential psychiatric care;
- The completed ISP must be based on input from school, home, other healthcare providers, the child, and family (or legal guardian);
- State treatment objectives that include measurable short-term and long-term goals and objectives, with target dates for achievement;
- Prescribe an integrated program of therapies, activities, and experiences designed to meet the treatment objectives related to the diagnosis; and
- Describe comprehensive discharge plans with related community services to ensure continuity of care upon discharge with the child’s family, school, and community.

The ISP must be reviewed at least every 30 days. The review must include:

- The response to services provided;
- Recommended changes in the plan as indicated by the child’s overall response to the ISP intervention;
- Determinations regarding whether the services being provided continue to be required; and

- Updates must be signed and dated by the service provider.

Therapeutic Passes

a. Therapeutic passes are permitted if the goals of the pass are part of the master treatment plan. The goals of a particular visit must be documented prior to granting the pass. When the child or adolescent returns from the pass, the response to the pass must be documented. Passes should begin with short lengths of time (e.g., 2-4 hours) and progress to a day pass. The function of the pass is to assess the recipient's ability to function outside the structured environment and to function appropriately within the family and community.

b. Overnight passes may occur only after the completion and documentation of successful day passes and as a part of the discharge plan. Outcomes of the therapeutic leave must be documented. No more than 24 days of therapeutic leave annually are allowed. Days of leave are counted from the date of admission to Medicaid-covered services at the A and B levels. Overnight passes from Level C Residential Treatment Services are not included in the allowance for Levels A and B. If a child/adolescent has successfully completed day passes at a higher level of care, the child/adolescent may be granted overnight passes prior to the completion of day passes at the new program if therapeutically indicated.

Limitations

DMAS will reimburse only for services provided in facilities or programs with no more than 16 beds. The total number of beds will be determined by including all beds located within the program/facility and on any adjoining or nearby campus or site.

If a provider operates separate residences that are 16 beds or less and are in distinctly different areas of a locality (for example, greater than one mile apart), the bed count will only apply to each residence. Each residence that is 16 beds or less will be eligible for Medicaid reimbursement.

Programs/facilities that only provide independent living services are not reimbursed.

The caseload of the clinical director must not exceed 16 clients including all sites for which the clinical director is responsible.

Service Units and Maximum Service Limitations

The service is limited to one unit daily. The rate includes payment for therapeutic services rendered to the child. Room and board costs are not included in the rate.

Day Treatment/Partial Hospitalization (H0035 Modifier HB)

Service Definition

Day Treatment/Partial Hospitalization services are programs of two or more consecutive hours per day, which may be scheduled multiple times per week and provided to groups of individuals in a non-residential setting.

Eligibility Criteria

In order for individuals to receive Medicaid-reimbursed Day Treatment/Partial Hospitalization Services, individuals must demonstrate a clinical necessity for the service arising from a condition due to mental, behavioral, or emotional illness that results in significant functional impairments in major life activities. Individuals must meet **at least two** of the following on a continuing or intermittent basis:

1. Have difficulty in establishing or maintaining normal interpersonal relationships to such a degree that they are at risk of hospitalization or homelessness because of conflicts with family or community.

2. Require help in basic living skills such as maintaining personal hygiene, preparing food and maintaining adequate nutrition, or managing finances to such a degree that health or safety is jeopardized.

3. Exhibit such inappropriate behavior that repeated interventions by the mental health, social services, or judicial system are necessary.

4. Exhibit difficulty in cognitive ability such that they are unable to recognize personal danger or recognize significantly inappropriate social behavior.

Required Activities

- Major diagnostic, medical, psychiatric, psychosocial, and psycho-educational treatment modalities designed for adults with serious mental disorders that require coordinated, intensive, comprehensive, and multi-disciplinary treatment but do not require inpatient treatment. Psycho-education refers to education on mental health topics to improve the recipient's behavioral, mental, or emotional condition. Psycho-education may include communication skills, problem solving skills, anger management, and interpersonal communication.

- A LMHP must perform a face-to-face evaluation/diagnostic assessment and authorize the services prior to initiation of service.

- An ISP must be completed by a QMHP or a LMHP within 30 days of service initiation.

- Services must be provided in accordance with the ISP.

- At a minimum, services are provided by qualified paraprofessionals under the supervision of a QMHP. (This will include current experienced staff who do not meet the criteria.)

- Supervision by the QMHP or LMHP is demonstrated by a review of progress notes, the recipient's progress toward achieving ISP goals and objectives and recommendations for change based on the recipient's status. Supervision must occur monthly. Documentation that supervision occurred must be in the recipient's clinical record and signed by the QMHP or LMHP. Individual, group, or a combination of individual and group supervision conducted by the QMHP or LMHP with paraprofessionals is acceptable.

- Paraprofessionals who do not meet the experience requirement listed in Chapter II may provide services for Medicaid reimbursement if they are working directly with a qualified paraprofessional on-site and supervised by a QMHP. Supervision must include on site observation of services, face-to-face consultation with the paraprofessional, a review of progress notes, the recipient's progress towards achieving ISP goals and objectives, and recommendations for change based on the recipient's status. Supervision must occur and be documented in the clinical record monthly.

- The program must operate a minimum of two continuous hours in a 24-hour period.

- A LMHP must perform a face-to-face evaluation and re-authorize services that are provided longer than 90 continuous days.

- If case management is being provided, there must be coordination with the case management agency.

Limitations

- Individuals shall be discharged from this service when they are no longer in an acute psychiatric state or when other less intensive services may achieve stabilization.

- Staff travel time is excluded.

Service Units and Maximum Service Limitations

- One unit of service is defined as a minimum of two, but less than four, hours on a given day.

- A maximum of 780 units may be offered per year.

Psychosocial Rehabilitation (H2017)

Service Definition

Psychosocial rehabilitation services are programs of two or more consecutive hours per day provided to groups of adults in a non-residential setting.

Eligibility Criteria

Individuals must demonstrate a clinical necessity for the service arising from a condition due to mental, behavioral, or emotional illness that results in significant functional impairments in major life activities. Individuals must meet at least two of the following on a continuing or intermittent basis:

1. Have difficulty in establishing or maintaining normal interpersonal relationships to such a degree that they are at risk of hospitalization or homelessness because of conflicts with family or community.

2. Require help in basic living skills, such as maintaining personal hygiene, preparing food and maintaining adequate nutrition, or managing finances to such a degree that health or safety is jeopardized.

3. Exhibit such inappropriate behavior that repeated interventions by the mental health, social services, or judicial system are necessary.

4. Exhibit difficulty in cognitive ability such that they are unable to recognize personal danger or significantly inappropriate social behavior.

To receive Psychosocial Rehabilitative services, the individual must meet one of the criteria listed below. The individual must:

1. Have experienced long-term or repeated psychiatric hospitalization; or

2. Lack daily living skills and interpersonal skills; or

3. Have a limited or non-existent support system; or

4. Be unable to function in the community without intensive intervention; or

5. Require long-term services to be maintained in the community.

Required Activities

- Prior to service initiation, there must be a face-to-face assessment by the QMHP and approved by the LMHP within 30 days which clearly documents the need for services.
- Within 30 days of service initiation, the ISP must be completed by a QMHP and must clearly document the need for the services.
- Every three months, the LMHP or the QMHP must review, modify as appropriate, and update the ISP.
- Services that continue for more than six months must be reviewed by an LMHP. The LMHP must document the need for continued services. The ISP must be rewritten at least annually.
- Perform education to teach the patient about mental illness and appropriate medication to avoid complications and relapse, provide opportunities to learn and use independent skills, and to enhance social and interpersonal skills within a supportive and normalizing program structure and environment.
- Services must be provided in accordance with the ISP.
- At a minimum, services are provided by qualified paraprofessionals under the supervision of a QMHP. (This will include current experienced staff who do not meet the criteria).
- Supervision is demonstrated by the QMHP by a review of the recipient's progress towards achieving ISP goals and objectives and recommendations for change based on the recipient's status. Supervision (this may be a group supervisory meeting with all paraprofessionals and a discussion of multiple recipients) must occur and be documented in the clinical record monthly.
- Paraprofessionals who do not meet the experience requirement listed in Chapter II may provide services for Medicaid reimbursement if they are working directly with a qualified paraprofessional on-site and supervised by a QMHP. Supervision must include on-site observation of services, face-to-face consultation with the paraprofessional (this may be a group supervisory meeting with all paraprofessionals and a discussion of multiple recipients), a review of the recipient's progress towards achieving ISP goals and objectives and recommendations for change based on the recipient's status. Supervision must occur and be documented in the clinical record monthly.
- The program must operate a minimum of two continuous hours in a 24-hour period.
- If case management is being provided, there must be coordination with the case management agency.

Service Units and Maximum Service Limitations

- One unit of service is a minimum of two, but less than four, hours on a given day.
- Time for field trips (off-site activities) is allowed if the goal is to provide an opportunity for supervised practice of socialization skills or therapeutic activities that are designed to increase the recipient's understanding or ability to access community services.
- Staff travel time is excluded.
- Vocational services are not reimbursable.
- A maximum of 936 units of Psychosocial Rehabilitation services may be offered per year.

Crisis Intervention (H0036)

Service Definition

Crisis intervention services are mental health care, available 24 hours a day, seven days per week, to provide assistance to individuals experiencing acute mental health dysfunction requiring immediate clinical attention. The objectives are:

- To prevent exacerbation of a condition;
- To prevent injury to the recipient or others; and
- To provide treatment in the least restrictive setting.

Eligibility Criteria

Crisis intervention services are provided following a marked reduction in the recipient's psychiatric, adaptive, or behavioral functioning or an extreme increase in personal distress.

Required Activities

- A Certified CSB Pre-screener or QMHP must complete and document a face-to-face assessment of the crisis situation; provide short-term counseling to stabilize the individual or family unit; provide access to further immediate assessment and follow-up; and link the individual and family with ongoing care to prevent future crises. If the assessment is performed by the QMHP, it must be reviewed and approved by a LMHP or Certified Pre-screener within 72 hours.
- Services may be provided to eligible individuals outside of the clinic and billed if it is clinically or programmatically appropriate, or both.

- Services may include office visits, home visits, pre-admission screenings, telephone contacts, or other client-related activities for the prevention of institutionalization. Note: Pre-admission screenings must be done by the CSB or, for children and adolescents under 21, by an independent team. Both the CSB team and the independent team must meet federal regulations for an independent team.

NOTE: Medicaid cannot be billed for crisis intervention services for a recipient under Emergency Custody Orders (ECOs) or Temporary Detention Orders (TDOs). Services may be billed up to the time an order for TDO or ECO is received. If the ECO ends without a TDO being called, services rendered after the ECO ends may be billed. Documentation of TDOs and ECOs must clearly delineate the separation of time. Refer to the *Hospital* Provider Manual, Appendix B, for further information.

- Staff travel time is excluded from billable time.

- Crisis intervention services may involve the recipient's family or significant others.

- An ISP is not required for newly admitted recipients. Inclusion of the service on the ISP is not required for the service to be provided to an active recipient on an emergency basis.

- An ISP prepared by a Certified Pre-screener or QMHP by the **fourth** face-to-face contact must be developed or revised to reflect treatment goals and interventions for scheduled short-term counseling.

- Services are provided by a Certified Pre-screener ***or*** QMHP.

- If case management is being provided, there must be coordination with the case management agency.

- Crisis Intervention (H0036) and Crisis Stabilization (H2019) may not be billed if the client is receiving intensive in-home services.

- If other clinic services are billed while the individual is receiving Crisis Intervention services, documentation must clearly support the separation of the services with distinct treatment goals.

Service Units and Maximum Service Limitations

- A unit of service is 15 minutes of Crisis Intervention. A maximum of 720 units of Crisis Intervention can be provided annually.

- A face-to-face contact with the recipient must occur during the crisis episode in order to bill Medicaid for Crisis Intervention Services. Other contacts, such as telephone calls and collateral contacts during the crisis episode, are reimbursable as long as the requirement for a face-to-face contact is met. Billable contacts which are directed toward crisis resolution for the recipient may occur prior to the face-to-face contact.

- Reimbursement will be provided for short-term crisis counseling contacts scheduled within a 30-day period from the time of the first face-to-face crisis contact.

Independent Team Certification

Federal regulations (42 C.F.R. § 441.152) require certification by an independent team that inpatient psychiatric services are needed for any recipient applying for Medicaid-reimbursed admission to a freestanding inpatient psychiatric facility. The certification must be current, within 30 days prior to placement. The independent team must include mental health professionals, including a physician. The independent team will be from the Community Services Board (CSB) serving the area in which the individual resides (or the area in which the individual is located). Pre-screenings are not reimbursable by Medicaid. For Comprehensive Services Act (CSA) children, the independent team will be the local Family Assessment and Planning Team (FAPT) or a collaborative, multidisciplinary team approved by the State Executive Council consistent with § 2.1-753-755 of the Code of Virginia. The majority of the team and the physician must sign the certification. Team members must have competence in the diagnosis and treatment of mental illness (preferably in child psychiatry) and have knowledge of the individual's situation (42 C.F.R. § 441.153).

A. Medicaid-reimbursed admission to a freestanding psychiatric facility can only occur if the independent team can certify that:

1. Ambulatory care resources (all available modalities of treatment less restrictive than inpatient treatment) available in the community do not meet the treatment needs of the recipient;

2. Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician; and

3. The services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed.

The certification of need for hospital admission and for non-CSA residential placements must be documented on the Pre-Admission Screening Report (DMH 224) or a similar form that must be signed by the team physician. (See the "Exhibits" section at the end of this chapter for a sample of this form.) It is not sufficient to merely check on the DMH 224 that each of the above certification-of-need criteria has been met. The team must indicate what less restrictive community resources have been accessed and failed to meet the individual's needs or why community resources will not meet the individual's current treatment needs.

For emergency acute care admissions, federal regulation (42 C.F.R. § 441.153) allows up to 14 days for the team responsible for the ISP in the facility to certify the admission. The certification must meet the criteria listed above. The team must meet the criteria for the treatment team (42 C.F.R. § 441.156) listed in this chapter.

An emergency admission is defined as a psychiatric hospitalization that is required because the individual is a danger to himself or others or when the individual is incapable of

developmentally appropriate self care due to a mental health problem. The admission follows a marked reduction in the individual's psychiatric, adaptive, or behavioral functioning or an extreme increase in personal distress.

If a child resided in a psychiatric residential facility and requires an acute psychiatric admission, and is returning to residential, a new certificate of need is required. The certification may be completed by the acute facility physician as long as the physician meets the criteria noted in federal regulations 42 C.F.R. § 441.152-153.

A physician, a physician assistant, or nurse practitioner, acting within the scope of practice and under the supervision of a physician, must recertify for each recipient that inpatient psychiatric services are needed. This must be made at least every 60 days.

Intensive Community Treatment (H0039)

Service Definition

Intensive community treatment (ICT) is an array of mental health services for adults with serious emotional illness who need intensive levels of support and service in their natural environment to permit or enhance functioning in the community. ICT has been designed to be provided through a designated multi-disciplinary team of mental health professionals. It is available either directly or on call 24 hours per day, seven days per week, 365 days per year.

Eligibility Criteria

The individual is best served in the community. The individual also must meet one or more of the following criteria:

1. Is at high risk for psychiatric hospitalization or for becoming or remaining homeless, or requires intervention by the mental health or criminal justice system due to inappropriate social behavior.

2. Has a history (three months or more) of a need for intensive mental health treatment or treatment for serious mental illness and substance abuse and demonstrates a resistance to seek out and utilize appropriate treatment options.

Required Activities

Medical psychotherapy, psychiatric assessment, medication management, and case management activities offered to outpatients outside the clinic, hospital, or office setting will be provided to individuals who are best served in the community.

- A LMHP certifies that the individual is in need of the services;
- An assessment by a QMHP documents need prior to initiation of the service;
- An ISP is initiated at time of admission and fully developed by the QMHP within 30 days of service initiation;

- Services are provided in accordance with the ISP;
- Services are provided by a QMHP or a paraprofessional under the supervision of a QMHP or LMHP;
- Documentation is created and maintained through a daily log of time spent in the delivery of services and a description of the activities and services provided. There must also be at least a weekly note documenting progress or lack of progress toward goals and objectives outlined in the ISP; and
- Coordination to ensure there is no duplication in services or billing and to ensure continuity of care.

Service Units and Maximum Service Limitations

- The service is initially covered for a maximum of 26 weeks. Continuation can occur if authorized for an additional 26 weeks annually.
- A unit equals one hour. There is a limit of 130 units annually.
- No billing is allowed during the same time period for any outpatient psychotherapy services or case management. Crisis stabilization may be billed if:

    1. Services are provided in a community-based residential setting; and
    2. Services meet the criteria for crisis stabilization services; and
    3. ICT is not billed for the days that crisis stabilization is billed.

- ICT services may be billed if the individual is brought to the clinic by ICT staff to see the psychiatrist. Documentation to support this intervention must be in the individual's clinical record.

<u>Crisis Stabilization (H2019)</u>

Service Definition

Crisis stabilization services are direct mental health care to non-hospitalized individuals (of all ages) experiencing an acute crisis of a psychiatric nature that may jeopardize their current community living situation. The goals are to avert hospitalization or re-hospitalization; provide normative environments with a high assurance of safety and security for crisis intervention; stabilize individuals in psychiatric crisis; and mobilize the resources of the community support system, family members, and others for ongoing maintenance, rehabilitation, and recovery.

Eligibility Criteria

To qualify for this service, individuals must demonstrate a clinical necessity for the service arising from a condition due to an acute crisis of a psychiatric nature that puts the individual at risk of psychiatric hospitalization. Individuals must meet **at least two** of the following criteria at the time of admission to the service:

1. Experiencing difficulty in maintaining normal interpersonal relationships to such a degree that they are at risk of hospitalization or homelessness or isolation from social supports.

2. Experiencing difficulty in activities of daily living (ADLs) such as maintaining personal hygiene, preparing food and maintaining adequate nutrition, or managing finances to such a degree that health or safety is jeopardized.

3. Exhibiting such inappropriate behavior that immediate interventions by mental health, social services, or the judicial system are necessary.

4. Exhibiting difficulty in cognitive ability (e.g., the individual is unable to recognize personal danger or recognize significantly inappropriate social behavior).

Required Activities

- Psychiatric assessment including medication evaluation, treatment planning, symptom and behavior management, and individual and group counseling. Service may be provided in any of the following settings, but shall not be limited to: (1) the home of a recipient who lives with family or another primary caregiver; (2) the home of a recipient who lives independently; or (3) community based programs licensed by DMHMRSAS to provide residential services but which are not institutions for mental disease (IMDs).

- Authorization following a face-to-face assessment by a QMHP, as certified pre-screener, or a LMHP that documents the need for the service and the anticipated duration of need, which is reviewed and approved by a LMHP within 72 hours.

- The ISP is developed or revised by the QMHP, a certified pre-screener, or a LMHP within ten business days of assessment or re-assessment.

- Services are provided in accordance with the ISP.

- Services are provided by a QMHP, a LMHP, **or** a Certified Pre-screener.

- Services must be documented through daily notes and a daily log of times spent in the delivery of services.

- If case management is being provided, there must be coordination with the case management agency.

Limitations

- Room and board, custodial care, and general supervision are not components of this service.
- Service is neither appropriate nor reimbursed for: (1) individuals with medical conditions which require hospital care; (2) individuals with a primary diagnosis of substance abuse; (3) individuals with psychiatric conditions which cannot be managed in the community, such as individuals who are of imminent danger to self or others; or (4) individuals residing in settings with a bed capacity that is greater than 16.
- Staff travel time is excluded.

Service Units and Maximum Service Limitations

- A billing unit is one hour.
- There is a limit of eight (8) hours a day for up to 15 **consecutive** days in each episode, up to 60 days annually.
- No concurrent billing is allowed during the same time period for clinic option outpatient mental health treatment or intensive community treatment. Billing for medication management only is permitted.

Mental Health Support (H0046)

Service Definition

Mental health support services are training and support to enable individuals with significant functional limitations to achieve and maintain community stability and independence in the most appropriate, least restrictive environment.

Eligibility Criteria

Individuals must demonstrate a clinical need for the service arising from a condition due to mental, behavioral, or emotional illness that results in significant functional impairments in major life activities. Individuals must meet **at least two** of the following criteria on a continuing or intermittent basis:

1. Have difficulty in establishing or maintaining normal interpersonal relationships to such a degree that they are at risk of hospitalization, homelessness, or isolation from social supports.
2. Exhibit such inappropriate behavior that repeated interventions by the mental health, social services, or judicial system are necessary.

3. Exhibit difficulty in cognitive ability such that they are unable to recognize personal danger or recognize significantly inappropriate social behavior.

4. Require help in basic living skills, such as maintaining personal hygiene, preparing food and maintaining adequate nutrition, or managing finances to such a degree that health or safety is jeopardized.

Individuals eligible for this service may have a dual diagnosis of either mental illness and mental retardation or mental illness and substance abuse disorder.

Required Activities

- Provide training in or reinforcement of functional skills and appropriate behavior related to the individual's health and safety, ADLs, and use of community resources; assistance with medication management, and monitoring health, nutrition, and physical condition.

- Document the assessment or evaluation, or both, prior to initiation or re-authorization of services completed by a QMHP no more than 30 days prior to the initiation or re-authorization of services. If the assessment is completed by a QMHP, a LMHP must review and sign the assessment. A LMHP must approve the assessment within 30 days of admission and re-authorization of services.

- Develop an ISP by a QMHP within 30 days of the initiation of services and indicate the specific supports and services to be provided and the goals and objectives to be accomplished.

- Provide services in accordance with the ISP.

- At a minimum, services are provided by qualified paraprofessionals under the supervision of a QMHP. (This will include current experienced staff who do not meet the criteria.)

  Supervision by the QMHP or LMHP is demonstrated by a review of progress notes, the individual's progress toward achieving ISP goals and objectives, and recommendations for change based on the individual's status. Supervision must occur monthly. Documentation that supervision occurred must be in the consumer's clinical record and signed by the QMHP or LMHP. Individual, group, or a combination of individual and group supervision conducted by the QMHP or LMHP with paraprofessionals is acceptable.

- Paraprofessionals, who do not meet the experience requirement listed in Chapter II, may provide services for Medicaid reimbursement if they are working directly with a qualified paraprofessional on-site and supervised by a QMHP. Supervision must include on-site observation of services, face-to-face consultation with the paraprofessional, a review of progress notes, the individual's progress towards achieving ISP goals and objectives, and recommendations for change based on the

individual's status. Supervision must occur and be documented in the clinical record monthly.

- Review the ISP every three months, modify it as appropriate, and update and rewrite the ISP at least annually.
- Services may be authorized for six consecutive months. Continuation of services may be authorized at six-month intervals or following any break in services by a LMHP based on an assessment and documentation of continuing need. A break in service is more than 30 days or if a case has been closed to this service.
- Document (through a daily log) the time involved in the delivery of services and make summary notes at least weekly.
- If the individual is receiving case management, there must be coordination with the case management agency.

Limitations

- Academic services are not reimbursable.
- Vocational services are not reimbursable.
- Room and board, custodial care, and general supervision are not components of this service and are not reimbursable.
- Individuals, who reside in facilities whose license requires that staff provide all necessary services, are not eligible for this service.
- Only direct face-to-face contacts and services to the recipient are reimbursable.
- Staff travel time is excluded.

Service Units and Maximum Service Limitations

- Billing is by unit [one unit is one (1) hour but less than three (3) hours].
- There is a limit of 372 units per year.

Expanded Prenatal Services (BabyCare) - Substance Abuse Treatment Services for Pregnant and Postpartum Women

Eligibility Criteria

The following criteria must be met for substance abuse treatment:

1. The woman must agree to participate in developing her own treatment plan; to comply with the treatment plan; to participate, support, and implement the ISP; to utilize appropriate measures to negotiate changes in her treatment plan; to fully participate in treatment; to comply with program rules and procedures; and to complete the treatment plan in full.

2. The woman must be pregnant at admission and intend to complete the pregnancy.

3. The woman must:

   a. Have used alcohol or other drugs within six weeks before referral to the program. If the woman was in jail or prison prior to her referral to the program, the alcohol or drug use must have been within six weeks prior to her incarceration in jail or prison; or

   b. Be participating in less intensive treatment for substance abuse and be assessed as high risk for relapse without more intensive intervention and treatment; or

   c. Within 30 days of admission, have been discharged from a more intensive level of treatment, such as hospital-based inpatient or jail- or prison-based treatment for substance abuse.

4. The woman must be under the active care of a physician, who is an approved Virginia Medicaid provider and has obstetrical privileges at a hospital that is an approved Virginia Medicaid provider. The woman must agree to reveal to her obstetrician her participation in substance abuse treatment and her substance abuse history and also agree to allow collaboration between the physician, the obstetrical unit of the hospital in which she plans to deliver or has delivered, and the program staff.

Required Activities

Assessments to determine level of need shall use the *American Society of Addiction Medicine (ASAM) Patient Placement Criteria for the Treatment of Substance-Related Disorders*, Second Edition, Revised 2001.

The following types of services or activities must be provided:

1. Substance abuse rehabilitation; counseling and treatment must include, but not necessarily be limited to, education about the impact of alcohol and other drugs on the fetus and on the maternal relationship; smoking cessation classes (if needed); relapse prevention to recognize personal and environmental cues that may trigger a return to the use of alcohol or other drugs; and the integration of urine toxicology screens and other toxicology screens, as appropriate, to monitor intake of illicit drugs and alcohol and provide information for counseling.

2. Training about pregnancy and fetal development, to be provided at a level and in a manner comprehensible for the participating women including, but not necessarily limited to, the impact of alcohol and other drugs on fetal development; normal physical changes associated with pregnancy as well as training in normal gynecological functions; personal nutrition; delivery expectations; and infant nutrition.

3. Initial and ongoing assessments specifically for substance abuse, including but not limited to, psychiatric and psychological assessments within 30 days of admission to the service if needed.

4. Symptom and behavior management as appropriate for co-existing mental illness, including medication management and ongoing psychological treatment.

5. Personal health care training and assistance, including:

    a. Education and referral for testing, counseling, and management of HIV;

    b. Education and referral for testing, counseling, and management of tuberculosis; and

    c. Education and referral for testing, counseling, and management of hepatitis.

6. Case coordination with providers of primary medical care, including obstetrical and gynecological services.

7. Training in decision-making, anger management, and conflict resolution.

8. Extensive discharge planning, with the woman, significant others, and representatives of service agencies. Documented discharge planning shall begin at least 60 days prior to the estimated delivery date, involving the woman, appropriate significant

others, and representatives of appropriate services agencies. The priority for discharge is to assure a stable, sober, and drug-free environment and treatment supports for the woman. If service is initiated less than 60 days prior to delivery date, discharge planning shall begin within two weeks of admission.

9. A contractual relationship with an OB/GYN.

10. The registered nurse case manager shall demonstrate competency in health assessment, mental health substance abuse, obstetrics and gynecology, case management, nutrition, cultural differences, and counseling.

11. The registered nurse case manager shall be responsible for coordinating the provision of all immediate primary care and shall establish and maintain communication and case coordination between the women in the program and necessary medical services, specifically with each obstetrician providing services to the women. In addition, the registered nurse case manager shall be responsible for establishing and maintaining communication and consultation linkages to high-risk obstetrical units, including regular conferences concerning the status of the woman and recommendations for current and future medical treatment.

12. A documented agreement with a high-risk pregnancy unit of a tertiary care hospital to provide 24-hour access to services and training and consultation to staff.

13. Access to services either through staff or contract:

    a. Psychiatric assessments, as needed, by a physician;

    b. Psychological assessments, as needed, by a licensed clinical psychologist;

    c. Psychological treatment, as appropriate, with clinical supervision by a licensed clinical psychologist;

    d. Medication management, as needed or at least quarterly, by a physician in consultation with the high-risk pregnancy unit, if appropriate; and

    e. Primary health care, if not available through other means including gynecological and obstetrical care.

14. Non-medical clinical supervision must be provided to staff at least weekly by a qualified substance abuse professional.

<u>Substance Abuse Residential Treatment for Pregnant Women (H0018 Modifier HD)</u>

Service Definition

Substance Abuse Residential Treatment for Pregnant Women services are comprehensive and intensive intervention services in residential facilities, other than inpatient facilities, for pregnant and postpartum women with serious substance abuse problems for the purposes of improving the

pregnancy outcome, treating the substance abuse disorder, strengthening the maternal relationship with existing children and the infant, and achieving and maintaining a sober and drug-free lifestyle.

Required Activities

The following services and activities must be provided:

- Documented assessment that Level III.3 or Level III.5 criteria are met for this service.
- A qualified substance abuse professional must conduct a face-to-face evaluation or diagnostic assessment, or both, within 30 days prior to admission and must authorize the services. Re-authorizations must be conducted every 90 days and after any absence of less than 72 hours that is not authorized by the program director. Medical care must be coordinated by a registered nurse case manager. The professional authorizing services cannot be the same professional providing non-medical clinical supervision.
- The program director must document the reason for granting any absence in the clinical record of the recipient.
- The ISP must be fully developed by the qualified substance abuse professional within one week after admission, involving the woman, appropriate significant others, and a representative of the appropriate service agencies. The ISP must be reviewed and updated every two weeks.
- Face-to-face therapeutic contact directly related to the ISP must be documented at least twice per week.
- An obstetric assessment must be completed and documented within a two-week period following admission.

Limitations

- No reimbursement for any other Community Mental Health/Mental Retardation/Substance Abuse Rehabilitative Services is available while the individual is participating in this program.
- Residential capacity shall be limited to 16 adults. Any dependent children shall not be included in the 16-bed count. No services may be provided to children.
- The minimum ratio of clinical staff to women shall assure sufficient staff to address the needs of the woman.
- Days of unauthorized absence cannot be billed.

Service Units and Maximum Service Limitations

- A billing unit is one day.
- There is a limit of 300 days per pregnancy, not to exceed 60 days postpartum. Unauthorized absence of less than 72 hours is included in this limit.
- An unauthorized absence of more than 72 hours will result in termination of Medicaid reimbursement.

Substance Abuse Day Treatment for Pregnant Women (H0015 Modifier HD)

Service Definition

Substance Abuse Day Treatment for Pregnant Women Services are comprehensive and intensive intervention services in a central location lasting two or more consecutive hours per day, which may be scheduled multiple times per week for pregnant and postpartum women with serious substance abuse problems for the purposes of improving the pregnancy outcome, treating the substance abuse disorder, strengthening the maternal relationship with existing children and the infant, and achieving and maintaining a sober and drug-free lifestyle.

Required Activities

The following services and activities must be provided:

- Documented assessment that Level II.1 or Level II.5 criteria are met for this service.
- A qualified substance abuse professional must conduct a face-to-face evaluation or diagnostic assessment, or both, within 30 days prior to admission and authorize the service. Re-authorizations must be conducted every 90 days and after any unauthorized absence of five consecutive days. The professional authorizing services cannot be the same professional providing non-medical clinical supervision.
- The program director must document the reason for granting any absence in the clinical record of the recipient.
- The ISP must be developed by the qualified substance abuse professional within 14 days after admission involving the woman, appropriate significant others, and representatives of appropriate service agencies. The ISP must be reviewed and updated every four weeks.
- An obstetric assessment must be completed and documented within a 30-day period following admission.
- Face-to-face therapeutic contact directly related to the ISP must be documented at least once per week.

- The minimum ratio of clinical staff to women shall assure sufficient staff to address the needs of the woman.

Limitations

- Only mental health crisis intervention services or mental health crisis stabilization may be reimbursed for recipients of day treatment services.
- More than two episodes of five-day absences from scheduled treatment without prior permission from the program director, or one absence exceeding seven (7) days of scheduled treatment without prior permission from the program director, shall terminate the services.

Services Units and Maximum Service Limitations

- A billing unit is a minimum of two (2) hours but less than four (4) hours.
- There is a limit of 400 units per pregnancy, not to exceed 60 days postpartum.

Mental Health Case Management (H0023)

Service Definition

Mental health case management assists individual children, adults, and their families with accessing needed medical, psychiatric, social, educational, vocational, and other supports essential to meeting basic needs.

Population Definitions

The following definitions are referred to in the discussion of the appropriate populations for services.

1. Serious Mental Illness

Adults, 18 years of age or older, who have severe and persistent mental or emotional disorders that seriously impair their functioning in such primary aspects of daily living as personal relations, self-care skills, living arrangements, or employment. Individuals who are seriously mentally ill and who have also been diagnosed as having a substance abuse disorder or mental retardation are included. The population is defined along three dimensions: diagnosis, level of disability, and duration of illness. All three dimensions must be met to meet the criteria for serious mental illness.

a. Diagnosis

There must be a major mental disorder diagnosed using the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV, Fourth Edition). These

disorders are: schizophrenia, major affective disorders, paranoia, organic or other psychotic disorders, personality disorders, or other disorders that may lead to chronic disability. A diagnosis of adjustment disorder or a V Code diagnosis cannot be used to satisfy these criteria.

b. Level of Disability

There must be evidence of severe and recurrent disability resulting from mental illness. The disability must result in functional limitations in major life activities. Individuals should meet at least two of the following criteria on a continuing or intermittent basis:

1) Is unemployed; is employed in a sheltered setting or supportive work situation; has markedly limited or reduced employment skills; or has a poor employment history.

2) Requires public financial assistance to remain in the community and may be unable to procure such assistance without help.

3) Has difficulty establishing or maintaining a personal social support system.

4) Requires assistance in basic living skills such as personal hygiene, food preparation, or money management.

5) Exhibits inappropriate behavior that often results in intervention by the mental health or judicial system.

c. Duration of Illness

The individual is expected to require services of an extended duration, or the individual's treatment history meets at least one of the following criteria:

1) The individual has undergone psychiatric treatment more intensive than outpatient care more than once in his or her lifetime (e.g., crisis response services, alternative home care, partial hospitalization, and inpatient hospitalization).

2) The individual has experienced an episode of continuous, supportive residential care, other than hospitalization, for a period long enough to have significantly disrupted the normal living situation.

2. Serious Emotional Disturbance

Serious emotional disturbance in children ages birth through 17 is defined as a serious mental health problem that can be diagnosed under the DSM-IV, or the child must exhibit all of the following:

a. Problems in personality development and social functioning that have been exhibited over at least one year's time; and

b. Problems that are significantly disabling based upon the social functioning of most children that age; and

c. Problems that have become more disabling over time; and

d. Service needs that require significant intervention by more than one agency.

3. At Risk of Serious Emotional Disturbance

Children aged birth through seven are considered at risk of developing serious emotional disturbances if they meet at least one of the following criteria:

a. The child exhibits behavior or maturity that is significantly different from most children of that age and which is not primarily the result of developmental disabilities or mental retardation; or

b. Parents, or persons responsible for the child's care, have predisposing factors themselves that could result in the child developing serious emotional or behavioral problems (e.g., inadequate parenting skills, substance abuse, mental illness, or other emotional difficulties, etc.); or

c. The child has experienced physical or psychological stressors that have put him or her at risk for serious emotional or behavioral problems (e.g., living in poverty, parental neglect, physical or emotional abuse, etc.).

Eligibility Criteria

- There must be documentation of the presence of serious mental illness for an adult individual or of serious emotional disturbance or a risk of serious emotional disturbance for a child or adolescent.

- The individual must require case management as documented on the ISP, which is developed by a qualified mental health case manager and based on an appropriate assessment and supporting documentation.

- To receive case management services, the individual must be an "active client," which means that the individual has a ISP in effect which requires regular direct or client-related contacts and communication or activity with the client, family, service providers, significant others, and others, including a minimum of one face-to-face contact every 90 days.

Required Activities

The following services and activities must be provided:

- Assessment and planning services, to include developing an ISP (does not include performing medical and psychiatric assessment, but does include referral for such assessment).

- An assessment must be completed by a qualified mental health case manager to determine the need for services. This assessment then serves as the basis for the ISP.

- The ISP must document the need for case management and be fully completed within 30 days of the initiation of the service. The case manager must modify the ISP as necessary, review it every three months, and rewrite it annually. The first quarterly review will be due the last day of the third month from the date of the ISP. Each subsequent review will be due by the last day of the third month following the month in which the last review was due and not on the date when the review was actually completed in the grace period. A grace period will be granted up to the last day of the fourth month following the month the review was due.

- Mandatory monthly case management contact, activity, or communication relevant to the ISP. Written plan development, review, or other written work is excluded.

- Linking the individual to services and supports specified in the ISP.

- Provide services in accordance with the ISP.

- Assisting the individual directly, which may include transportation, for the purpose of developing or obtaining needed resources, including crisis assistance supports.

- Coordinating services and treatment planning with other agencies and providers.

- Enhancing community integration through increased opportunities for community access and involvement and creating opportunities to enhance community living skills to promote community adjustment.

- Making collateral contacts with significant others to promote implementation of the service plan and community adjustment.

- Monitoring service delivery as needed through contacts with service providers as well as periodic site visits and home visits.

- Education and counseling, which guide the individual and develop a supportive relationship that promotes the service plan. Counseling, in this context, is not psychological counseling, examination, or therapy. The case management counseling is defined as problem-solving activities designed to promote community adjustment and to enhance an individual's functional capacity in the community. These activities must be linked to the goals and objectives on the Case Management ISP.

- Educational activities do not include group activities that provide general information and that do not provide opportunities for individualized application to specific recipients. For example, group sessions on stress management, the nature of serious mental illness, or family coping skills are not case management activities.

- A face-to-face contact must be made at least once every 90-day period. The purpose of the face-to-face contact is for the case manager to observe the recipient's condition, to verify that services which the case manager is monitoring are in fact being provided, to assess the recipient's satisfaction with services, to determine any unmet needs, and to generally evaluate the recipient's status.

Case Management services are intended to be an individualized client-specific activity between the case manager and the recipient. There are some appropriate instances where the case manager could offer case management to more than one recipient at a time. The provider bears the burden of proof in establishing that the case management activity provided simultaneously to two or more recipients was consumer-specific. For example, the case manager needs to work with two consumers, each of whom needs help to apply for income assistance from Social Security. The case manager can work with both recipients simultaneously for the purpose of helping each recipient obtain a financial entitlement and subsequently follow-up with each recipient to ensure he or she has proceeded correctly.

Service Units and Maximum Service Limitations

- The unit for case management is a month.

- Billing can be submitted for case management only for months in which direct or client-related contacts, activity, or communications occur.

- Reimbursement is provided only for "active" case management consumers.

- No other type of case management may be billed concurrently with targeted case management.

Reimbursement for case management services for individuals age 21-64 in Institutions for Mental Disease (IMD) is not allowed. IMDs are not allowed. An IMD is a facility that is primarily engaged in the treatment of mental illness and is greater than 16 beds.

- There is no maximum service limit for case management services except case management services for individuals residing in institutions or medical facilities. Case management services may not be provided for institutionalized individuals who are age 64 and under. Services rendered during the time the individual is not

admitted to the IMD may be billed, even if during the same month as the admission to the IMD.

- To bill for case management services, two conditions must be met. The services may not duplicate the services of the institutional discharge planner, and the community case management services provided to the institutionalized individual are limited to one month of service, 30 days prior to discharge from the facility. Case management for institutionalized individuals may be billed for no more than two non-consecutive pre-discharge periods in 12 months.

- Case management may not be billed when a child is receiving Intensive In-Home Services.

- Case management may not be billed when a client is open to Intensive Community Treatment.

Case management services for the same individual must be billed by only ONE type of case management provider.

Case Management Agency Requirements

1. The assessment and subsequent reassessments of the individual's medical, mental, and social status must be reflected with appropriate documentation. The initial comprehensive assessment must also include current documentation of a medical examination, a psychological/psychiatric evaluation, and a social assessment.

2. All ISPs (originals, updates, and changes) must be maintained for a period not less than five years from the date of service or as provided by applicable state laws, whichever is longer. The recipient or legal representative and any relevant family members or friends involved in the development of the ISP must sign the ISP.

3. There must be documentation that the choice of a provider has been offered when services are initiated and when there are changes in services. The choice must be documented in writing by having the recipient (or parent or guardian when appropriate) sign a document verifying freedom of choice of providers was offered and this provider was chosen.

4. A release form must be completed and signed by the recipient for the release of any information.

5. There must be an ISP from each provider rendering services to the recipient. The ISP is the service plan developed by the individual service provider related solely to the specific tasks required of that service provider and the desired outcomes. ISPs help to determine the overall ISP for the individual. The ISPs must state long-term service goals and specified short-term objectives in measurable terms. For case management services, specific objectives for monitoring, linking, and coordinating

must be included. The ISP is defined in the "Exhibits" section at the end of this chapter.

6. There must be documentation that notes all contacts made by the case manager related to the ISP and the individual's needs.

MONITORING AND RE-EVALUATION OF THE SERVICE NEED BY THE CASE MANAGER

The case manager must continuously monitor the appropriateness of the recipient's ISP and make revisions as indicated by the changing support needs of the recipient. At a minimum, the case manager shall review the ISP every three months to determine whether service goals and objectives are being met, satisfaction with the program, and whether any modifications to the ISP are necessary. Providers must coordinate reviews of the ISP with the case manager every three months.

This quarterly re-evaluation must be documented in the case manager's file. The case manager must have monthly activity regarding the recipient and a face-to-face contact with the recipient at least once every 90 days.

The case manager must revise the ISP whenever the amount, type, or frequency of services rendered by the individual service providers changes. When such a change occurs, the case manager must involve the individual in the discussion of the need for the change.

RECIPIENT'S RIGHT TO APPEAL AND A FAIR HEARING

Any decision that affects the individual's receipt of Medicaid-covered services may be appealed to DMAS. The individual must be notified in writing of the right to a hearing and the procedure for requesting a hearing, both at the time of the application and at the time of any action.

Whenever a service is terminated, suspended, or reduced, the recipient must receive written notification of the pending action within 10 days, except for the following:

1. Advance notice will be reduced to five days if the facts indicate the action is necessary because of probable fraud; and

2. Advance notice does not need to be sent if:

   - The recipient has stated in writing that he or she no longer wishes to receive Medicaid services;

   - The recipient gives information that requires the termination of Medicaid, and the recipient knows that this action is the result of giving the information;

   - The recipient has been admitted to an institution where he or she is ineligible for services under the Virginia *State Plan for Medical Assistance*;

- The recipient moves to another state and has been determined eligible for Medicaid in the new jurisdiction; or

- The recipient's whereabouts are unknown. The agency will determine that the recipient's whereabouts are unknown if mail sent to the recipient is returned as undeliverable.

The notification must include the following statement:

> "You may appeal this decision by notifying, in writing, the Appeals Division, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, Virginia 23219. This written request for an appeal must be filed within thirty (30) days of this notification. If you file an appeal before the effective date of this action, (date), services may continue during the appeal process. However, if this decision is upheld by the Appeals Division, you will be required to reimburse the Medical Assistance Program for services provided after (date)."

QUALIFIED MEDICARE BENEFICIARIES - COVERAGE LIMITATIONS

Qualified Medicare Beneficiaries (QMBs) are only eligible for Medicaid coverage of Medicare premiums and of deductible and co-insurance up to the Medicaid payment limit less the recipient's co-payment on allowed charges for all Medicare-covered services. Their Medicaid verification will provide the message "QUALIFIED MEDICARE BENEFICIARY-QMB-MEDICAID PAYMENT LIMITED TO MEDICARE CO-INSURANCE AND DEDUCTIBLE." The Medicare co-insurance is limited to the Medicaid fee when combined with the Medicare payment.

QUALIFIED MEDICARE BENEFICIARIES - EXTENDED COVERAGE LIMITATIONS

Recipients in this group will be eligible for Medicaid coverage of Medicare premiums and of deductible and co-insurance up to the Medicaid payment limit on allowed charges for all Medicare-covered services plus coverage of all other Medicaid-covered services listed in Chapter I of this manual. Their Medicaid verification will provide the message "QUALIFIED MEDICARE BENEFICIARY-QMB EXTENDED." These recipients are responsible for co-pay for pharmacy services, health department clinic visits, and vision services.

CLIENT MEDICAL MANAGEMENT (CMM) PROGRAM

As described in Chapters I and VI, the Medicaid Program may designate certain recipients to be restricted to specific physicians and pharmacists. When this occurs, it is noted on the recipient's Medicaid card. A Medicaid-enrolled physician, who is not the designated primary provider, may provide and be paid for services to these recipients only:

- In a medical emergency situation in which a delay in treatment may cause death or result in lasting injury or harm to the recipient;
- On written referral from the primary physician, using the Practitioner Referral Form (DMAS-70). This also applies to physicians affiliated with the non-designated primary provider in delivering the necessary services; and
- For other services covered by DMAS, which are excluded from the CMM Program requirements.

The mental health services described in this chapter are excluded from the CMM Program, and none of the specific CMM provisions apply to these services. However, mental health providers are encouraged to coordinate treatment with the primary physician whose name appears on the recipient's eligibility card as other services and medications are monitored routinely.

EXHIBITS

UNIFORM PREADMISSION SCREENING FORM

This form is to be completed by a qualified professional designated by the Community Services Board to determine if an individual meets criteria for civil commitment or is in need of voluntary or involuntary admission to a psychiatric hospital. Please refer to the Uniform Preadmission Evaluation Procedures and the Continuity of Care Guidelines.

DATE _____ **TIME (From** _____ **To**_____**)** **DISPOSITION: VOL TDO OTHER CASE NO.**_____

I. PERSONAL DATA

Name: _____ Age: _____ Date of Birth: _____

Address: _____
(Street) (City or County) (State) (Zip Code)

Phone: ( )_____ Marital Status: _____ SSN: _____

Physical description: _____ _____ _____ _____ _____ _____
(Sex) (Race) (Height) (Weight) (Hair Color) (Eye Color)

Emergency Contact: _____ Relationship to Client: _____

Address: _____
(Street) (City or County) (State) (Zip Code)

Phone: Home ( )_____ Work ( )_____

Monthly Income: $_____ SSI/SSDI: $_____ Payee: _____ Veteran: Y N ?

Insurance: Y N ? _____ _____
(Name of Insurance Company) (Group/Plan Number)

Medicaid: Y N ? #_____ Medicare: Y N ? #_____

(If under 18) School Division: _____ School Attending: _____ Grade: _____ Special Education: Y N

CSB of Origin: _____ Contacted: Y N N/A **PRAIS Code**

Name of CSB Staff Contacted:_____ Phone ( )_____

II. LEGAL DATA

Pending legal charges: Y N - If yes, complete the following information: Nature of charges (if known): _____

Date of hearing (if known): _____ Court of Jurisdiction: _____ Client serving a sentence: Y N ?
NGRI Conditional Release: Y N ? Probation/Parole: Y N ? Contact:_____

III. COLLATERAL SOURCES OF INFORMATION		Yes	No	N/A
Client Record	(Agency)			
Individual Requesting Evaluation	(Name & Relationship to Patient)			
Primary Therapist	(Name)			
Other	(Name & Relationship to Patient)			

IV. FOR LOCAL USE

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V. MEDICAL

Primary Care Provider: _____ Phone ( )_____

Medical History & Current Medical Problems/Symptoms:_____

_____

_____

Medication: Current prescribed psychotropic and other medications (include dosage, schedule, etc. if known)

	Name	**Dose**	**Schedule**	**Length of Time Taken**
1.				
2.				
3.				
4.				
5.				

Recent medication changes: Y N ? (If yes, explain) _____

Allergies or adverse side effects to medications: Y N ? (If yes, explain)_____

_____

Has client complied with recommended medication and treatment plans? Y N ? (If no, describe nature of non-compliance)_____

_____

VI. MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT: Service providers (e.g., Eastern State Hospital, CSB, CSB contractual agency, private provider, etc.) and services and/or treatment provided.

	Service Provider/Facility	**Services/Treatment Provided**	**Date Last Seen**
1.			
2.			
3.			
4.			

VII. PRESENT SITUATION (Include information such as precipitating events, stressors and variation, if any, from baseline level of functioning. _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

3

VIII. MENTAL STATUS EXAM (Circle all that apply)

Appearance:	WNL	unkempt	poor hygiene		bizarre	tense	rigid	
Behavior/Motor Disturbance:	WNL	agitation	guarded	tremor	manic		impulse control	psychomotor retardation
Orientation:	WNL	disoriented:	time	place	person	situation		
Speech:	WNL	pressured	slowed	soft/loud	impoverished	slurred	other	
Mood:	WNL	depressed	angry/hostile	euphoric	anxious	anhedonic	withdrawn	
Range of Affect:	WNL	constricted	flat	labile	inappropriate			
Thought Content:	WNL	delusions	grandiose	ideas of reference	paranoid	obsessions	phobias	
Thought Process:	WNL	loose associations	flight of ideas	circumstantial	blocking	tangential	perseverative	
Perception/ Sensorium:	WNL	hallucinations:	auditory	visual	olfactory	tactile	illusions	
Memory:	WNL	impaired:	recent	remote	immediate			
Appetite:	WNL	poor	Weight: loss	gain	Appetite: increased	decreased		
Sleep:	WNL	hypersomnia	onset problem	maintenance problem				
Insight:	WNL	blaming	little	none				

Estimated Intellectual/Functional Capacity: above average | average | below average | diagnosed MR

Explain clinically significant findings: _____

_____

_____

_____

_____

_____

_____

IX. SUBSTANCE ABUSE ASSESSMENT (Check if no current use _____)

	Hx	Past 24 hrs	Blood Present	Drug of Choice	Frequent (Past 30 days)	Method	Last used
Tremors			N/A	**Primary:**			
Seizures			N/A	**Secondary:**			
DT's			N/A	**Comments/Test Results:**			
Vomiting			Y N				
Diarrhea			Y N				

4

X. RISK ASSESSMENT

Suicide Potential: Hx of ___Attempts Current __Attempt __Ideation ___Intent Plan: ____Vague Plan: ____Defined ____Means Active ____Psychosis Current ___Substance Abuse

Homicide Potential: Hx of ___Assault Assault or __ Attempt __ Ideation ___Intent Plan: ___ Vague Plan: ____Defined ____Means Active ___ Psychosis Current ___Substance Abuse

Specify: _____

_____

_____

XI. DIAGNOSIS: DSM IV (P=Provisional, H=Historical) **GAF:** _____

Axis I: _____

Axis II: _____

XII. FINDINGS (Circle)

X **Is / is not** mentally ill and/or abusing substances.
X **Is / is not** an imminent danger to self or others.
X **Is / is not** able to care for self.
X **Is / is not** capable of consenting to voluntary treatment/hospitalization.
X **Is / is not** willing to be treated voluntarily.
X There **are / are not** less restrictive community alternatives to serve this person.

_____

XIII. DISPOSITION RECOMMENDATION (Check appropriate "PreDetention" box if evaluation is conducted prior to the issuance of a T.D.O. Check appropriate "PreHearing" box if evaluation is conducted after the issuance of a T.D.O. but prior to the commitment hearing.)		
PreDetention		**PreHearing**
	Client does not meet criteria for hospitalization and/or commitment and should be encouraged to participate in community based services.	
Not Applicable	Involuntary commitment to outpatient services because client meets criteria for involuntary commitment, community alternatives are available for involuntary commitment, and client is incapable or unwilling to consent to voluntary treatment.	
	Voluntary hospitalization because client does not meet criteria for involuntary commitment, has the capacity to consent to voluntary treatment, requires treatment in a hospital and has requested said treatment.	
Not Applicable	Voluntary hospitalization because the client requires treatment in a hospital, has the capacity to consent to treatment, and if, in the presence of the special justice and under court order, the client agrees to a voluntary period of treatment up to 72 hours and to give 48 hours notice to leave in lieu of involuntary commitment for up to 180 days.	
	Involuntary hospitalization because client meets criteria for involuntary hospitalization and is incapable of consenting to voluntary treatment.	
	Involuntary hospitalization because client meets criteria for involuntary hospitalization, is capable of consenting to voluntary treatment, but is unwilling to be treated voluntarily.	

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XIV. FINDINGS OF HEARING EVALUATOR (*To be completed if "PreHearing" Disposition Recommendation differs from "PreDetention" Disposition Recommendation.*):

XV. TREATMENT AND DISCHARGE PLANNING (*to be completed only if inpatient treatment is recommended).*

Individuals who can assist in treatment and discharge planning (i.e., family, discharge planner, therapist, family physician, etc.)

Name	**Phone No.**	**Relationship to Client**
1.		
2.		
3.		

Inpatient treatment goals: _____

Services to be considered in planning for discharge:

____medication management	____substance abuse services	____housing /residential services
____case management	____financial support/entitlement	____medical/dental/nutritional services
____outpatient (ind., fam., group)	____adult or child protective services	____legal assistance/advocacy
____psychosocial/day treatment	____transportation	____nursing home care

____other_____

_____ _____
Signature of Prescreener Prescreening Agency/Board

_____ _____
Print Name Here Date

_____
Signature of Hearing Evaluator

_____ _____
Print Name Here Date

Individualized Service Plan (ISP) Guide

Statement of Principle: A comprehensive assessment and an Individualized Service Plan (ISP) are the foundation of services designed specifically for a client.

I. Assessments of Clients

A. Face-to-face assessments will be conducted to identify a client's physical, emotional, behavioral, and social strengths, preferences, and needs, as applicable.
B. Assessments will be performed prior to development of the ISP.

II. Plan for Service

A. An ISP defines and describes the goals, objectives, and expected outcomes of service(s).
B. The client's needs and preferences will be considered when the service plan is developed and revised.
C. The client and principle service provider or service team are documented participants in service planning.
D. Involvement of the family, guardian, or others in developing the ISP will be consistent with laws protecting confidentiality, privacy, and the rights of minors.

III. ISP - Minimum Required Elements

The ISP will include, at a minimum:

A. A summary or reference to the assessment;
B. Goals and measurable objectives for addressing each identified need;
C. The services, supports, and frequency of service to accomplish the goals and objectives;
D. Target dates for accomplishment of goals and objectives;
E. Estimated duration of service;
F. The role of other agencies if the plan is a shared responsibility; and
G. The staff responsible for coordination and integration of services, including the persons of other agencies if the plan is a shared responsibility.

IV. Progress Notes or Other Documentation

Signed and dated progress notes or other documentation will be used to document the services provided, and the implementation and outcomes of service plans.

V. Services Plan Reviews

Service plans will be reviewed as required for each specific service or at least every six months with goals and objectives updated, if indicated. Reviews will be conducted with the client and in consultation with other service providers and will be signed and dated by the person responsible for the coordination and integration of services.

From DMHMRSAS (Department of Mental Health, Mental Retardation, and Substance Abuse Services) Rules & Regulations for the Licensure of Facilities and Providers of Mental Health, Mental Retardation, and Substance Abuse Services.